STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005020	A. BUILDING _____ B. WING _____	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW REGIONAL MEDICAL CENTER	11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of two State complaints. Complaint Number: IN00088634 Unsubstantiated: Lack of sufficient evidence. IN00089847 Substantiated: No deficiencies related to the allegations are cited. Facility Number: 005020 Date of Survey: 08/09/11 through 08/10/11 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Parkview Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 08/22/11	S 000		